payment data. (This step does not include certain demonstration project revenues, as described in subsection 7 below. For special rules regarding the 1994-95 payment adjustment year, see subsection 6 below.)

(3) "CRRP Revenues" (CRRP_RV).

"CRRP Revenues" will be determined based on the results of the applicable hospital-specific survey.

(4) "Emergency Services/Supplemental Payments Revenues" (EMS_RV).

(a) Except as provided for in clause (d) or in subsection 7, the Department shall determine the hospital's revenue amount relating to the program under Welfare and Institutions Code Section 14085.6 ("S.B. 1255 program"), with respect to services to be rendered during the subject payment adjustment year, based on the best information available as of the data determination date, in the fashion described below.

(b) In determining the S.B. 1255 revenue amount to be included for the subject payment adjustment year, the Department shall use, in the following order of availability, the amount that:

(i) Is set forth in any contract between the hospital and the State as negotiated by the California Medical Assistance Commission ("CMAC") pursuant to Section 14085.6;

(ii) Has been agreed upon by the particular hospital and CMAC staff, but has not yet been formally approved by CMAC or by the hospital;

(iii) Represents the latest offer made by CMAC staff to the particular hospital; or,

(iv) The hospital was granted with respect to the payment adjustment year immediately prior to the subject payment adjustment year, but only if (1) subclause (i), (ii), or (iii) do not apply, and (2) the hospital has communicated to CMAC an intent to participate in the S.B. 1255 program for the subject payment adjustment year. Should this clause (iv) apply for a hospital, the amount included by the Department shall not exceed the amount of S.B. 1255 program payments the hospital has requested from CMAC for the subject payment adjustment year.

(c) In the event that none of the data described in clause (b) is available as of the data determination date, the Department shall assume that the S.B. 1255 program revenue for the particular hospital for the subject payment adjustment year will be the amount the hospital was granted with respect to the payment adjustment year immediately prior to the subject payment adjustment year. The Department, in cooperation with CMAC, shall notify hospitals of the existence and potential applicability of this provision at the time the S.B. 1255 program is initiated each year.

(d) With respect to the 1994-95 and 1995-96 payment adjustment years, the Department shall take into account, except as otherwise provided in subsection 7, the particular Medi-Cal contract amendment(s) for S.B. 1255 program payments effective for each period that have been entered into at the time that the computations pursuant to this Section J are made for each of the respective subject payment adjustment years.

(e) For purposes of clauses (b), (c), and (d) above, the Department shall use the contracted amount when the contracted "days of service" are equal to or less than 12 months. In the event that the "days of service" extend beyond 12 months, the Department shall reduce the total contract amount to reflect 12 months of revenue by dividing the total contract amount by the number of months represented in the contracted "days of service" and multiplying that number by 12.

(f) Except as provided in subclause (iv), for the 1996-97 payment adjustment year and subsequent payment adjustment years, if a hospital meets the conditions set forth in subclause (i), the Department shall take into account additional S.B. 1255 revenue amounts pursuant to subclauses (ii) and (iii).

(i) The hospital entered into a Medi-Cal contract amendment(s) since the last data determination date (September 15, 1995 and thereafter) that resulted in S.B. 1255 program payments to the hospital relating to services rendered in a fiscal year preceding the subject payment adjustment year, and such S.B. 1255 program payments were not included in the OBRA 1993 limit calculation for the year(s) during which such services were rendered.

(ii) The Department shall determine whether the inclusion of the additional S.B. 1255 program revenue described in subclause (i) would have resulted in a reduction in the hospital's disproportionate share payment amounts for the payment adjustment year for which the additional S.B. 1255 program payments were received.

(iii) To the extent that the additional S.B. 1255 revenue described in subclause (i) would have reduced the hospital's OBRA 1993 limit in an amount that would have resulted in the hospital surpassing its OBRA 1993 limit for a previous payment adjustment year, the amount of the additional S.B. 1255 revenue that would have caused the hospital to surpass its OBRA 1993 limit for any such prior year shall be added to the S.B. 1255 revenue amount for the subject payment adjustment year as determined under clauses (b) - (e).

(iv) Subclauses (i) through (iii) shall not apply to a hospital participating in a federal Medicaid demonstration project, if such demonstration project provides a repayment arrangement agreed to by the parties regarding disproportionate share payment adjustment amounts.

(5) "Targeted Case Management Revenues" (TCM_RV).

"Targeted Case Management Revenues" will be determined based on the results of the applicable hospital-specific survey.

(6) "Uninsured Cash Payments" (UNINS_RV).

Except as otherwise provided in this Section J, "Uninsured Cash Payments" will be derived from the applicable OSHPD report (as referred to in paragraph b of subsection 3). "Uninsured Cash Payments" shall be calculated as the sum of the inpatient and outpatient net revenues reported for "Other Payors" on page 12 of the OSHPD report. The amount so determined from the applicable OSHPD report will be trended forward into the subject payment adjustment year (as referred to in subparagraph (1) of paragraph b of subsection 4.

7. Projected "demonstration project revenues" (DEMO RV) are determined based on the terms and conditions of an approved federal Medicaid demonstration project, but only to the extent set forth in paragraph b of subsection 7.

The computation of "Medi-Cal/Uninsured Revenues" (MCUN_RV) is therefore expressed as follows:

MCUN_RV = MIP_RV + MOP_RV + CRRP_RV + EMS_RV + TCM_RV + UNINS_RV + DEMO RV.

5. Application of Limit

a. For the 1994-95 payment adjustment year, the OBRA 1993 limits shall apply only to public hospitals. With respect to the 1994-95 payment adjustment year, the total disproportionate share payment adjustment amounts described at page 18 et seq. of this Attachment paid or payable to each eligible hospital that is owned or operated by the State (or by an instrumentality or a unit of government within the State) shall not exceed 100% of the hospital's OBRA 1993 limit as calculated pursuant to this Section J with respect to the subject payment adjustment year; provided, however, that payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396r-4(g)(2) of Title 42 of the United States Code) shall be limited to 200% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year.

b. For the 1995-96 and subsequent payment adjustment years, the OBRA 1993 limits shall apply to all eligible hospitals. With respect to any particular payment adjustment year, no eligible hospital shall receive total payment adjustment amounts under this Attachment in an amount that exceeds 100% of the hospital's OBRA 1993 limit as calculated pursuant to this Section J with respect to the subject payment adjustment year, except as follows: (1) with respect to the 1997-98 and 1998-99 payment adjustment years, the payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396r-4(g)(2) of Title 42 of the United States Code) shall be limited to 175% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year; and (2) with respect to the 1999-2000 payment adjustment year and subsequent payment adjustment years, the payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396-4(g)(2) of Title 42 of the United States Code) shall be limited to 100% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year, unless federal law sets forth or authorizes a different percentage figure or amount to be used for such hospital for such purposes for the subject payment adjustment year, in which case such different percentage figure or amount shall apply for such hospital for such payment adjustment year.

c. For the 1995-96 payment adjustment year, the OBRA 1993 limits shall be applied as set forth in subparagraph (3) of paragraph e of subsection 1 of Section I of this Attachment. For subsequent payment adjustment years, the OBRA 1993 limits shall be applied with respect to each year after performing computations under subsection 5 of Section D of this Attachment and as specified in other provisions of this Attachment. The OBRA 1993 limits shall be applied to the amounts computed for all affected hospitals prior to the computations of transfer amounts under Section 14163 of the Welfare and Institutions Code.

d. Where a payment adjustment amount that is otherwise paid or payable to an eligible hospital under this Attachment is; or would be, above the limits described in this Section J, the payment adjustment amount shall be subject to the provisions of subsection 9 of Section D of this Attachment.

6. Special Rules relating to 1994-95 Payment Adjustment Year.

With respect to the 1994-95 payment adjustment year, the OBRA 1993 limit shall be calculated for each eligible hospital in accordance with the methodology set forth in subsection 4 above, except as follows.

a. In determining expenses pursuant to paragraph b of subsection 4 (other than MAA and CRRP expenses), the Department shall use data from the annual OSHPD reports filed by hospitals for fiscal periods ending during the 1993 calendar year.

b. The applicable Medicare hospital market basket percentage increases, as referred to in subparagraph (1) of paragraph b of subsection 4 shall be 4.3% and 3.6% for FFY 1994 and FFY 1995, respectively (58 Fed.Reg. 46270; 59 Fed.Reg.45330). The Medicare hospital market basket percent increase for FFY 1994 shall be adjusted for varying hospital OSHPD reporting periods, as specified in subparagraph (1) of paragraph b of subsection 4.

c. The calculation of "Medi-Cal Inpatient Revenues," as referred to in subparagraph (1) of paragraph c of subsection 4, shall be based on data relating to revenues for inpatient services, regardless of dates of service, for which payment was made by of on behalf of the Department to a hospital, under present or previous ownership, during the 1994 calendar year.

d. The calculation of "Medi-Cal Outpatient Revenues," as referred to in subparagraph (2) of paragraph c of subsection 4, shall be based on data relating to revenues for outpatient services, regardless of dates of service, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the 1994 calendar year.

e. "Uninsured Cash Payments," as referred to in subparagraph (6) of paragraph c of subsection 4, will be derived from the applicable annual OSHPD report referred to in paragraph a above. The amount so determined will be trended forward into the 1994-95 payment adjustment year based on the applicable Medicare hospital market basket percent increases set forth in paragraph b above.

7. Special Rules for Federal Medicaid Demonstration Projects.

a. This paragraph a shall apply where a federal demonstration project may occur, but the effective date of the project has not been approved by the federal government as of the data determination date for the subject payment adjustment year. This paragraph shall also apply where the federal government has approved the demonstration project, but the effective dates of the project do not include any time periods during the subject payment adjustment year. In such situations, any additional Medi-Cal and uninsured expenses and revenues that could potentially arise with respect to the subject payment adjustment year solely as a result of the hospital's participation in the demonstration project shall not be included in the computations set forth in subsection 4.

b. This paragraph b shall apply only where the federal government has approved a demonstration project, the federal approval has been issued prior to the data determination date for the subject payment adjustment year, and some or all of the federally approved effective dates of the project fall within the subject payment adjustment year. In such situations, to the extent that the Department determines (with concurrence of HCFA) that the terms and conditions of an approved federal Medicaid demonstration project constitute federally approved variations from the provisions of this Section J (including expenses, calculations, data elements, data collection and revenues federally recognized under the demonstration project for the computation of the OBRA 1993 limits hereunder), such terms and conditions of the approved demonstration project shall govern.

8. Department's Discretion

a. Notwithstanding any other provision of this Section J, but subject to paragraph b, below, the Department shall (with concurrence of HCFA) have the discretion to vary the mechanisms and sources, or formulas specified herein if the department finds that such variance is required to:

(1) Comply with federal law or regulations,

(2) Take into account the unavailability of particular data elements, or the impracticality of making a particular calculation, or

(3) Avoid inequitable or unintended results not consistent with OBRA 1993 or with the overall purpose and intent of this Section J.

b. A variance pursuant to paragraph a will be limited to making minor or insignificant adjustments to any formula, calculation, or methodology specified in this Section J, or to the specified sources of data to be used in any such formula, calculation, or methodology. These minor adjustments will be limited to instances when the format for reporting data used by the Department has been changed by the agency responsible for issuing the report, or when the information in an agency's report is incomplete and comparable information is available from the agency. Any minor adjustment made pursuant to this Section J will be made prior to the final calculation of OBRA '93 limits, and will not be made to effect a retroactive adjustment. A variance under this Section J will not be made to correct errors in data

submitted by a reporting hospital to the agency responsible for issuing the particular report, or to make any other correction, change, or adjustment in the data reported by a particular hospital. A variance under this Section J will not be made to alter the fundamental structure or general scheme of this Section J; where significant changes in the formulas, calculations, or methodologies specified in this Section J are necessary, the Department will submit a state plan amendment to the Health Care Financing Administration in the normal course.

K. Supplemental Lump-Sum Payment Adjustments - June 30, 1997

1. For the 1996-97 payment adjustment year, each eligible hospital that remains in operation as of June 30, 1997, shall also be eligible to receive a supplemental lump-sum payment adjustment, that shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date.

2. The availability of supplemental payment adjustments under this paragraph shall be determined as follows:

   a. The projected total payment adjustment amount for each hospital, as determined by the department, including any reductions arising from payment limitations under this Attachment, shall be identified. For each hospital, this amount shall be identical to the amount used for the same hospital in the calculations regarding transfer amounts under subdivision (h) of Section 14163 of the California Welfare and Institutions Code for the 1996-97 state fiscal year.

   b. The total amount of all per diem payment adjustment amounts under this section, whether paid or payable, that are applicable to the period July 1, 1996, through June 30, 1997, shall be determined for each hospital. The applicability of the per diem payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

   c. The amount determined under paragraph b. for each hospital shall be subtracted from the amount identified under paragraph a. for each hospital. If the remainder is a positive figure for the particular hospital, the supplemental lump-sum adjustment for the hospital shall be the positive remainder amount, which shall be payable because the facility is a disproportionate share hospital in operation as of June 30, 1997.

   d. The Department shall make interim and final payments of the supplemental lump-sum payments under this paragraph on or before September 30, 1997.

3. For purposes of complying with section 13621 of the Omnibus Budget Reconciliation Act of 1993, the hospital-specific limitation described in Section J shall be applicable to amounts otherwise paid or payable with respect to the 1996-97 payment adjustment year.